Complete Summary

GUIDELINE TITLE

Adapting your practice: treatment and recommendations for homeless children with otitis media.

BIBLIOGRAPHIC SOURCE(S)

Bonin E, Brammer S, Brehove T, Hale A, Hines L, Kline S, Kopydlowski MA, Misgen M, Obias ME, Olivet J, O'Sullivan A, Post P, Rabiner M, Reller C, Schulz B, Sherman P, Strehlow AJ, Yungman J. Adapting your practice: treatment and recommendations for homeless children with otitis media. Nashville (TN): Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc.; 2003. 24 p. [27 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Otitis media in homeless children

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Otolaryngology
Pediatrics
Speech-Language Pathology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physician Assistants
Physicians
Public Health Departments
Social Workers
Speech-Language Pathologists

GUIDELINE OBJECTIVE(S)

To recommend adaptations in standard clinical practices to improve the quality of health care for homeless children with otitis media and foster better outcomes of that care

TARGET POPULATION

Homeless children with otitis media

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Patient history, including housing status, living conditions and medical home; exposure to viral illness and smoke; breast versus bottle feeding; sleep disturbance; hearing difficulties and delayed speech; development and behavior problems; missed school; prior ear infections and treatment; other medical history of child or family (asthma, anemia, HIV, tuberculosis [TB], sexually transmitted disease [STDs], alcohol or drug problems, etc.)
2. Physical examination, including general exam according to standard clinical guidelines (Early and Periodic Screening, Diagnosis and Treatment [EPSDT] services) and otologic examination
3. Diagnostic tests, such as pneumatic otoscopy, tympanometry, and hearing screening

Management/Treatment

1. Education and self-management, including educating parents about signs, symptoms, and common recurrence of otitis media; explaining benefits of breast feeding (if not contraindicated); educating about risks of child's exposure to second-hand smoke and risks from chronic untreated ear infections; stressing importance of completing antibiotic therapy

2. Medications, including simple regimen of once daily oral antibiotics with minimal gastrointestinal side effects (amoxicillin, five-day course of azithromycin) or intramuscular antibiotics (single dose of ceftriaxone) for acute otitis media only; aids to adherence (chart to record medicine taken, measuring device for liquid preparations, medicine box for pills); pain medication; referral to ear, nose and throat (ENT) specialist (otolaryngologist), if needed
3. Referral to social worker or case manager for assistance in applying for health insurance (Medicaid/SCHIP) and/or obtaining free/low-cost drugs; assistance in getting prescriptions filled, assistance with transportation to appointments if needed; detail a communication strategy with the parent if no phone is available; assistance in scheduling a timely specialty appointment.
4. Recognizing associated problems and complications, including repeated exposure to viral infection and second-hand smoke in congregate living situations, hearing problems and speech delays secondary to chronic ear infections, lack of transportation, lack of a means to communicate with health care providers, financial barriers to pharmaceuticals, poor adherence, familial stress
5. Follow-up, including recheck of child with acute infection within a week; ENT referral if purulent drainage persists >1-2 weeks; early referral to audiologist/speech pathologist for any hearing loss, balance problem, speech delay or sleep disorder with effusion/chronic infection; referral for myringotomy/tympanostomy if chronic otitis media is suspected; encouraging regular source of primary care; outreach, case management and transportation assistance to facilitate return visits and referrals

MAJOR OUTCOMES CONSIDERED

- Incidence/prevalence of otitis media among sheltered homeless children
- Hearing loss/speech delays related to chronic ear infections
- Prevalence of smoking among homeless parents; completion of a smoking cessation program
- Regular source of primary care
- Health disparities between homeless and general U.S. populations

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Searches of MEDLINE, SocABS, and PsycInfo databases were performed. Bibliographies compiled by the Bureau of Primary Health Care´s Homeless Information Resources Center were also searched.

NUMBER OF SOURCE DOCUMENTS

This guideline is adapted from three primary sources.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Network Steering Committee and other primary care providers, representing Health Care for the Homeless (HCH) projects across the United States, devoted several months during 2002–03 to developing special recommendations for the treatment and prevention of ear infections in children who lack residential stability. These recommendations reflect their collective experience in serving children who are homeless.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline developer's Advisory Committee identifies, in the original guideline document, the clinicians who reviewed and commented on the draft recommendations prior to publication, including experienced Health Care for the Homeless practitioners and medical experts in the care of otitis media. The guideline was field tested by clinicians in designated Health Care for the Homeless projects during the summer of 2003. Evaluation criteria included clarity, flexibility and ease of use; relevance to the care of homeless clients or those at risk of becoming homeless; inclusion of strategies to promote outreach and case management and ensure follow-up; sufficiently detailed to ensure that similar practitioners would offer similar treatment in the same circumstances; and sufficiently complete to enable new clinicians to use them for homeless clients. Evaluators found that the guideline met all of these criteria and recommended future development of "short forms" of this and other adapted clinical guidelines to facilitate use in a variety of clinical settings.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Diagnosis and Evaluation

History

- Housing and medical home. Ask specific questions to determine whether the family is homeless ("Where do you live? Who lives where you live? How long have you lived there? Where did you live before?") At every visit, document patient´s housing status and living conditions, list barriers to consistent treatment, and ask if child has a "medical home" (regular source of primary care). If so, is family able to access this medical home? Is transportation a barrier? Does patient's regular primary care provider demonstrate sensitivity to the needs of homeless children and families? Ask these questions in several different ways to elicit desired information.
- Exposure to viral illness. Ask whether patient is in school or daycare, how many children s/he is playing with, and if anyone in recent contact with the child is sick. (Exposure to viral illness in congregate living situations is a primary risk factor for otitis media.)
- Exposure to smoke. Ask whether parent or other "household" member smokes, and whether mother smoked during pregnancy with this child. Prevalence of smoking among homeless people is higher than in the general population. (Parental smoking and passive smoke exposure increase the incidence of otitis media.) Ask about passive exposure to substances other than nicotine, such as marijuana or crack cocaine.
- Breast vs. bottle feeding. Ask if infant is being breastfed, and if not, why not, to identify cultural or other barriers to breastfeeding. Ask this in a nonjudgmental way. An infant who is breastfed obtains passive immunity from his mother. Although the exact reason is unclear, children who are breastfed seem to have fewer ear infections than bottle fed infants (Hanson, 1999).

  Mothers who are actively using amphetamine, cocaine, heroin, or phencyclidine should not be encouraged to breastfeed their infants (American

Academy of Pediatrics [AAP], 2001). Provider must also take into consideration possible effects of other drugs or any maternal infection with potential for transmission to infant in breast milk before encouraging a mother to breastfeed. Breastfeeding is not recommended for human immunodeficiency virus (HIV)-positive mothers if there is a safe alternative (i.e., if infant formula is available, if there is access to clean water to prepare formula milk and cleanse bottles and nipples, if refrigeration is available to store prepared formula, and if mother has ability to manage formula feeding with appropriate hygiene) (Centers for Disease Control and Prevention [CDC], 2001).

If bottle feeding, ask whether infant holds bottle and drinks from it while lying on back. (This may increase risk of ear infection.) Bottle "propping" may be indicative of parental stress and/or lack of time to spend holding child. Mothers who are depressed or distracted by the highly stressful experience of homelessness may not be able to give adequate attention to their children.

- Sleep disturbance. Ask if child has trouble sleeping related to apparent ear discomfort. Interrupted sleep can raise already high stress levels for a homeless family, especially if sleeping in a shelter.
- Hearing difficulties, delayed speech. Ask when child was last screened for hearing. Ask questions to elicit information about possible hearing difficulties and speech delays. (Does child have trouble listening? Does child speak as well as other children of the same age?) Recognize that developmental delays may also result from poor prenatal care, premature birth, and/or weak parenting skills, which are frequent consequences of homelessness.
- Development/ behavior. Inquire about child´s interaction with family members and behavior at daycare or school. Difficulty hearing can cause a child to be frustrated and may be misdiagnosed as a behavior problem. Hearing and/or speech problems may be masked by behavior problems that can affect child´s emotional development. Behavior problems also occur in response to the stress of living in a shelter and feeling ostracized by other children. (Evaluations such as the Denver Developmental Screening Tests (DDST) are appropriate in this setting.)
- Missed school. If child is school age, inquire about attendance, especially missed days due to ear discomfort or other illnesses.
- Prior ear infections/treatment. Ask about patient's past ear infections (how many?) and whether/how they were treated, in addition to symptoms and duration of current complaint. Determine if child received a full course of any antibiotic treatments. Lack of treatment or inadequate/incomplete therapy for an ear infection may result in late complications such as mastoiditis or hearing loss.
- Other medical history. Always take the opportunity to ask about medical conditions for which homeless people are at increased risk (e.g., asthma, anemia, malnutrition/obesity, lead toxicity, tuberculosis, sexually transmitted diseases, alcohol, and drug problems) that may directly or indirectly affect the child's health. This is especially important, given homeless families' limited access to health screening, mental health care, substance abuse treatment, and specialty care in general. Ask about HIV infection in parent or child. HIV-infected children are susceptible to recurrent ear infections. They may also have speech and language disabilities related to effects of HIV virus on the developing central nervous system (Retzlaff, 1999)

Physical Examination

- General. Do complete pediatric exam at every visit, according to standard clinical guidelines (e.g., American Academy of Pediatrics guidelines: www.aap.org/policy/paramtoc.html) and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services required for children on Medicaid (See: Early and Periodic Screening, Chapter 05, State Medicaid Manual: www.cms.hhs.gov/manuals/pub45/pub_45.asp). Whatever the chief complaint, use visit as an opportunity to identify and address all problems. Remember that this may be your only contact with the family. Homeless families may not see a medical provider unless their child is sick.
- Otologic examination. Good evaluation of appearance of tympanic membranes is vital for prompt diagnosis. If cerumen is present, enough must be removed to allow inspection of eardrum. Irrigation should be avoided unless there is no suspicion of underlying perforation of tympanic membrane. Because follow-up may not be possible, use of a curette and otoscope is preferable for homeless children; use of hydrogen peroxide drops may help dissolve wax, but requires one or more return visits, which may be more difficult to arrange with homeless families. Clear distinction should be made between a well aerated middle ear, one that is filled with sterile effusion (retracted appearance, dull, with loss of light reflex), and one with acute otitis media filled with purulent effusion (bulging with a white or yellow creamy appearance). Redness alone (in absence of fluid) does not indicate a middle ear infection.

Diagnostic Tests

- Pneumatic otoscopy, tympanometry. These tests help to confirm presence of fluid behind the tympanic membrane, and thus support the diagnosis of acute otitis media or middle ear effusion. While not necessary to make the diagnosis, they can be helpful if examiner is unsure of middle ear status by routine otoscopy alone.
- Hearing screening. Do a routine audiometric screening at every visit, especially if child has a history of otitis media. Suspicion of hearing loss should trigger referral to an audiologist to conduct a formal diagnostic test. Emphasize importance of Early and Periodic Screening (including hearing), Diagnosis, and Treatment (EPSDT) as part of primary care–covered services under Medicaid, for which most homeless children qualify.

Plan and Management

Education, Self-Management

- Common occurrence. Explain to parent that otitis media is very common and may recur often, to prevent loss of confidence in medical providers. Main message is that treatment must not be delayed.
- Signs and symptoms. Educate parent about signs and symptoms of otitis media. Pulling or rubbing ear, fluid coming from ear, hearing/balance problems, and fever are indications of immediate need to see a medical provider (but ear touching alone does not necessarily mean an ear infection).
- Breast feeding, bottle propping. Educate parent about advantages of breast feeding (if no contraindications) and risks of bottle propping in

preventing otitis media. Provide lactation guide at shelters, drop-in centers, and meal sites used by homeless families. Refer to Women, Infants, and Children (WIC) program, if available in community.

- Prevention. Explain what parent can do to reduce child's susceptibility to future infections: smoke-free environment, smoking cessation program for parent, frequent hand washing to prevent spread of viral infections in shelter, etc. Some clinicians recommend a harm reduction approach to parental smoking. For example, suggest that parent smoke outdoors, wear a poncho while smoking, and remove it before holding child to reduce child´s exposure to second-hand smoke.
- Risks of delayed/ interrupted treatment. Explain risks to hearing, speech, emotional development, and school performance from chronic untreated ear infections.
- Antibiotics. Emphasize that all antibiotics prescribed must be completed. (Don´t stop when symptoms cease or use for next infection.) Urge parent to use standard measurements for antibiotics (not just "a swig"). Provide measuring device. Educate parent about possible side effects of antibiotics, especially diarrhea.
- After hours. Tell parent what to do and number to call if problems arise outside clinic hours.

Medications

- Antibiotics should be used in cases of acute otitis media only. Although there is some evidence that antibiotics can be deferred while awaiting spontaneous resolution of infection, this approach is not appropriate in homeless populations, as close follow-up is not assured. Antibiotics should not be used for chronic sterile effusion, but hearing evaluation is important and an ear, nose and throat (ENT) referral may be necessary.
- Simpler regimen. In general, shorter courses of antibiotics given once daily (such as five-day course of azithromycin) are preferred over more complicated regimens. Consideration should be given to intramuscular routes, such as single dose of ceftriaxone, in which medication delivery is assured. Medications that require refrigeration should be avoided if client does not have access to refrigeration. For a child over five years of age, consider use of capsules as an alternative to liquid preparations, which often require measuring and refrigeration. Capsules are relatively easy to swallow, even for a young child, or can be opened and sprinkled in food, if necessary.
- Prescriptions. Find out if patient has health insurance coverage; if not, refer to social worker or case manager for assistance in applying for Medicaid or the State Children's Health Insurance Program (SCHIP), which cover prescription drugs recommended to treat otitis media. Most homeless children are eligible for Medicaid or SCHIP. If patient is uninsured or if co-payments required by patient's health plan present a financial barrier to treatment, consider giving patient medication samples on site, if available, recognizing possible difficulty in obtaining continued medication. Investigate other options for reduced-cost drugs (e.g., pharmaceutical companies' Patient Assistance Programs for low-income individuals and/or US Department of Health and Human Services' 340B Pharmaceutical Discount program, if eligible [http://bphc.hrsa.gov/opa/howto.htm]).

Assist family in getting prescriptions filled, especially if required to use an approved pharmacy within a managed care network. Know what medications are on your state´s Medicaid/SCHIP drug formularies and which ones require pre-authorization by a managed care plan. If possible, prescribe medications that do not require prior authorization, which delays treatment and may discourage homeless families from getting prescriptions filled.

- Gastrointestinal (GI) upsets. Prescribe medications with minimal gastrointestinal side effects. Diarrhea is more difficult for homeless families to manage because of limited access to diapers and facilities for cleansing child. Maintaining adequate hydration can also be a problem if fluids are not readily available.
- Pain medication. Provide treatment for pain. Clinicians often under-treat pain associated with acute otitis media. Homeless families may delay pain management while moving from place to place. A crying child in pain increases the stress experienced by homeless families.
- Aids to adherence. Give parent a cross-off chart to keep track of medication administered to child. Use medication boxes for pills. Make sure parent can read prescription labels and all written instructions/educational materials.

Associated Problems/Complications

- Congregate living in shelters or doubled up with other families increases homeless children´s risk of exposure to viral infection, which may increase the incidence of otitis media.
- Parental smoking. High prevalence of tobacco smoking among homeless people increases risk of otitis media in their children. Refer parent to smoking cessation program; counsel to explore readiness to change. Consider child's exposure to other smoke from marijuana, crack cocaine, etc.
- Hearing problems. Multiple/chronic ear infections can result in hearing loss that may affect child´s attachment to parent, emotional and social development, and how parent interacts with child.
- Speech delays. Homeless children have more problems with speech delays unrelated to otitis media than poor housed children. These problems are exacerbated by ear infections. Many homeless children have delayed social and verbal skills, which make it difficult to assess for speech delays.
- Lack of transportation. Homeless families often have difficulty obtaining transportation to specialty appointments. Help client with transportation to needed health services.
- Financial barriers. Lack of health insurance or required co-payments for pharmaceuticals may make it difficult for homeless families to obtain prescribed medications. Help family obtain all entitlements for which child is eligible (including Medicaid/SCHIP) and/or reduced-cost drugs available through public or private patient assistance programs.
- Poor adherence. Assess parent's ability to understand directions and follow through with treatment. Help parent seek assistance, if needed (e.g., substance abuse counseling, help from childcare center´s staff). Use nonjudgmental language. Acknowledge how complicated homeless peoples´ lives are, and the fact that there are conflicting priorities. Be sure parent understands importance of this treatment for the child. Explain things to patient/parent on a level they can understand. Articulate expectations that are realistic but high.

- Familial stress. A child with acute or chronic illness presents another source of stress for a family already dealing with the highly stressful experience of homelessness. Help to alleviate stress by facilitating access to stable housing, supportive services, and other resources (e.g., through childcare centers and schools).

Follow-Up

- Frequency. Re-check child in 5 to 7 days after initial treatment is initiated to ensure that an acute infection is resolving (fluid may take months to go away). If infection has not improved, a change in medical therapy may be necessary. Patients who have purulent drainage from ear (otorrhea) should be seen by an ENT doctor if drainage persists for more than a week or two. Children with sterile middle ear fluid should be followed up in about 2 to 3 months and referred to an ENT doctor if fluid persists.
- Primary care provider (PCP). Share information with patient's primary care provider (if any); refer immediately; facilitate transportation. Make sure provider understands family's living situation and special needs.
- Specialists. More aggressive referrals are needed for homeless children, who require access to professionals in multiple clinical disciplines. Access to specialists is limited in many places, especially rural areas. Work toward establishing relationships with specialists in your community. Develop referral relationships with specialists willing to accept Medicaid patients or provide pro bono care for children who do not qualify for public health insurance. (Recognize that most homeless children are eligible for Medicaid or SCHIP.)
- Referral to audiologist/speech pathologist. Primary care providers should have a low threshold for referral of homeless children for hearing and speech screening. Homeless people have special problems with delayed treatment when continuity of care is lacking. If referral is delayed, there may not be another opportunity for assessment and intervention to arrest damaging results of otitis media. Any hearing loss, balance problem, speech delay, or sleep disorder with effusion or chronic ear infection should trigger referral to an audiologist and/or a speech pathologist. If speech/hearing loss milestones are unclear, refer. Educate clinicians to whom you refer patients about family´s living conditions.
- Myringotomy/tympanostomy. Consider referral if chronic otitis media is suspected. Typical thresholds for surgery are fluid with hearing loss for three months, or 5 to 6 episodes of otitis media in a six-month period. However, early referral may be necessary, since it may be difficult to document these criteria in homeless children.
- Case management. Whenever possible, involve a social worker or case manager to facilitate return visits. Give appointment slips to parent/family member, social worker, and shelter staff.
- Outreach. Coordinate medical care with an outreach worker.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

This is a guideline adapted from the following sources:

- American Academy of Pediatrics. Managing otitis media with effusion in young children. Practice guidelines. Pediatrics. 1994 Nov. 94(5). www.aap.org/policy/otitis.htm.
- American Academy of Family Practitioners. Otitis Media with Effusion in Young Children, Clinical Recommendations, 1994, 2002: http://www.aafp.org/x1596.xml.
- Uphold & Graham. Acute otitis media. Clinical Guidelines in Family Practice. Gainesville, FL: Barmarrae, 1998: 338–346.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate care for homeless children with otitis media
- Prevention of hearing loss/speech delays secondary to chronic ear infections

POTENTIAL HARMS

Drug-resistant infections secondary to improper use of antibiotics

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The information and opinions expressed in the guideline are those of the Advisory Committee for the Adaptation of Clinical Guidelines for Homeless Patients with otitis media, not necessarily the views of the U.S. Department of Health and Human Services, the Health Resources and Services Administration, or the National Health Care for the Homeless Council, Inc.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

This guideline has been distributed to 161 Health Care for the Homeless (HCH) grantees across the United States and to several academic programs that train pediatricians or family practitioners. These and other recommended clinical practice adaptations to optimize care for homeless persons are also being used in

workshops at national and regional conferences, including the National HCH Conference sponsored by the Bureau of Primary Health Care/HRSA/HHS.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

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- Uphold & Graham. Acute otitis media. Clinical Guidelines in Family Practice. Gainesville, FL: Barmarrae, 1998: 338–346.

DATE RELEASED

2003

GUIDELINE DEVELOPER(S)

Health Care for the Homeless (HCH) Clinician's Network - Medical Specialty Society
National Health Care for the Homeless Council, Inc. - Private Nonprofit Organization

SOURCE(S) OF FUNDING

The Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services

GUIDELINE COMMITTEE

Advisory Committee for the Adaptation of Clinical Guidelines for Homeless Children with Otitis Media

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The Health Care for the Homeless (HCH) Clinicians' Network has a stated policy concerning conflict of interest. First, all transactions will be conducted in a manner to avoid any conflict of interest. Secondly, should situations arise where a Steering Committee member is involved in activities, practices or other acts which conflict with the interests of the Network and its Membership, the Steering Committee member is required to disclose such conflicts of interest, and excuse him or herself from particular decisions where such conflicts of interest exist.

No conflicts of interest were noted during preparation of this guideline.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the National Health Care for the Homeless Council, Inc. Web site.

Print copies: Available from the National Health Care for the Homeless Council, Inc., P. O. Box 60427, Nashville, TN 37206-0427; Phone: (615) 226-2292

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on May 24, 2004. The information was verified by the guideline developer on June 24, 2004.

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